



## FREQUENTLY ASKED QUESTIONS FOR PROVIDERS

### WHAT DOES "POLST" STAND FOR?

POLST stands for Practitioner Orders for Life-Sustaining Treatment.

### WHAT IS THE POLST FORM?

POLST is a set of medical orders that help give seriously ill or frail elderly patients more control over their end-of-life care. Produced on a distinctive green form and signed by both the doctor/APN and patient/surrogate, POLST specifies the types of medical treatment that a patient wishes to receive toward the end of life. As a result, POLST can prevent unwanted or medically ineffective treatment, reduce patient and family suffering and help ensure that patients' wishes are honored.

### WHAT INFORMATION IS INCLUDED ON THE POLST FORM?

Documentation on the POLST form includes:

- Goals of care for the patient
- Preferences regarding cardiopulmonary resuscitation attempts
- Preferences regarding use of intubation and mechanical ventilation for respiratory failure
- Preferences for artificially administered nutrition and hydration
- Other specific preferences regarding medical interventions that are desired or declined.

### WHY WAS POLST DEVELOPED?

POLST was developed in response to seriously ill patients receiving medical treatments that were not consistent with their wishes. The goal of POLST is to provide a framework for healthcare professionals so they can provide the treatments patient DO want and avoid those treatments that patients DO NOT want.

### IS POLST MANDATED BY LAW?

Filling out a POLST form is entirely voluntary. However, New Jersey law requires that medical orders contained in a POLST be followed by healthcare professionals and provides immunity from civil or criminal liability to those who comply in good faith with a patient's POLST.

### WHO SHOULD HAVE A POLST FORM?

POLST is designed for seriously ill patients or those who are medically frail with limited life expectancy, regardless of their age.

### DOES THE POLST FORM REPLACE A TRADITIONAL ADVANCE DIRECTIVE?

The POLST form complements an Advance Directive and is not intended to replace that document. An Advance Directive may still be necessary to appoint a legal healthcare decision maker and is recommended for all adults, regardless of their health status.

### IF SOMEONE HAS A POLST FORM AND AN ADVANCE DIRECTIVE THAT CONFLICT, WHICH TAKES PRECEDENCE?

Ideally, the values expressed on both documents should be the same. If there is conflict between the two documents, a conversation with the patient or surrogate should take place to determine the most current preferences as soon as possible. The POLST and the Advance Directive can then be updated based on these more current treatment choices. If this cannot be done and a crisis ensues, care should be provided in accordance with the most recent document, whether it be the Advance Directive or the POLST.

## **WHO SHOULD DISCUSS AND COMPLETE THE POLST FORM WITH PATIENTS?**

Having a conversation with a patient about end-of-life issues is an important and necessary part of good medical care. The law allows a physician or an advance practice nurse to complete a POLST form. In many cases, these practitioners will initiate conversations with their patients to understand their wishes and goals of care. Depending on the situation and setting, other trained staff members – such as nurses, palliative care team members, social workers or chaplains – may also play a role in starting the POLST conversation. However, physicians/APNs are responsible for the final clarification of those preferences and documentation of the appropriate orders on the POLST form.

## **CAN A POLST FORM BE COMPLETED FOR PATIENTS WHO CAN NO LONGER COMMUNICATE THEIR TREATMENT WISHES?**

Yes. A physician or advance practice nurse can complete the POLST form based on a legally recognized surrogate decision maker's understanding of the patient's preferences. The surrogate can then sign the POLST form on behalf of the patient.

## **WHAT SHOULD BE DONE WITH THE FORM AFTER IT IS COMPLETED AND SIGNED?**

- The original POLST form, on green paper, stays with the patient at all times. If the patient is transferred to another setting, the original POLST form goes with the patient.
- In the acute care or long term care settings, the original form should be kept in the patient's medical record or file in the doctors order section, and copies should be made or scanned into the medical record to maintain.
- At home, patients should be instructed to place the original form in a visible location so it can be found easily by emergency medical personnel – usually on a table near the patient's bed or on the refrigerator. Copies may be kept for record-keeping.

## **CAN A PATIENT'S POLST FORM BE CHANGED?**

Yes, the POLST can be modified or rescinded by a patient with decision-making capacity, verbally or in writing, at any time. Changes may also be made by the patient's legally recognized surrogate, if the patient previously authorized the surrogate, via the POLST form, to make such modifications. Any changes to the POLST form should be made in collaboration with the patient's physician or advance practice nurse.

## **WHEN SHOULD A PATIENT'S POLST FORM BE REVIEWED?**

It is good clinical practice to review a patient's POLST form when any of the following occur:

- The patient is transferred from one medical or residential setting to another
- There is a significant change in the person's health status, or there is a new diagnosis
- The patient's treatment preferences change.

## **ARE FAXED COPIES AND PHOTOCOPIES VALID? MUST GREEN PAPER BE USED?**

Faxed copies and photocopies are valid. Green paper is preferred and should be used to distinguish the form from other forms in the patient's medical record; however, the form will be honored on any color paper as long as it contains the appropriate signatures.

## **WHERE IS POLST BEING USED NOW?**

POLST was originally developed in Oregon. There are a number of states that have established POLST programs or are currently developing programs. For more information on the national POLST paradigm, including published research and a complete listing of states using POLST, visit [www.POLST.org](http://www.POLST.org)

## **DOES A POLST FORM TAKE THE PLACE OF OTHER DNR ORDER FORMS?**

The patient's preferences for cardiopulmonary resuscitation attempts and airway management are contained in a POLST form and should be honored upon receipt. However, hospitals and nursing facilities may still use other forms of Do Not Resuscitate orders in addition to the POLST in keeping with institutional policies. The N.J. Out-of-Hospital DNR form that has been utilized by EMS since 1997 will remain valid and should be honored upon receipt. However, eventually, the POLST form will evolve to replace most other order forms for resuscitation in all settings. Until that time, it is appropriate to honor all forms that are current and have not been rescinded or replaced by a more current form.

## **DOES THE POLST FORM EXPIRE?**

No. However, it is recommended that a POLST form be reviewed frequently and especially when there is a change in medical condition, transfer to a different level of care setting or a change in preferences of the patient.

## **WHAT HAPPENS IF A POLST FORM IS WILLFULLY IGNORED?**

Healthcare professionals who intentionally ignore a POLST form will be subject to discipline for professional misconduct pursuant to Section 8 of P.L. 1978, c. 73 (C.45:1-21). Hospitals and healthcare facilities that intentionally ignore a POLST are subject to fines. Others such as family members who willfully conceal, ignore, hide, forge, falsify or fail to disclose a valid POLST form are guilty of a crime in the fourth degree. If the act of willfully concealing or withholding the form leads to the involuntary earlier death of the patient, it shall constitute a crime of the first degree.

## **WHY IS THE FIRST SECTION ABOUT "GOALS OF CARE"?**

The goals of care for a patient's healthcare plan are an important part of the comprehensive understanding of the patient's medical condition, expected prognosis and the patient's specific goals, such as wanting to spend time at home with family, wanting to get treatments that allow the patient to live until a loved one's wedding or wanting to be comfortable and pain free regardless of length of life. These specific goals should be part of every conversation with patients about their treatment plans and the translation of those goals into physician/APN orders to accomplish those goals.

